

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

Reg. Dist. No.

3253

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 3 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek, Md.		d. STREET ADDRESS Fishing Creek Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sallie Middle o'Neil Last Aaron		4. DATE OF DEATH March 10 1958					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Creighton				14. MOTHER'S MAIDEN NAME Phoebe Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records Eastern Shore State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO (b) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 2 Min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO ? Arteriosclerotic C-V Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Senile brain disease YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/10/58	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/58		22c. NAME OF CEMETERY OR CREMATORIUM Hoosier Church		22d. LOCATION (City, town, or county) Fishing Creek Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.				24a. REC'D BY REGISTRAR MAR 18 '58		24b. REGISTRAR'S SIGNATURE Al...b...e...r...t...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S

MAR 18 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3260

CERTIFICATE OF DEATH

Reg. Dist. No. 03218

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 1yr. 9mo. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) Robert BEVERLY Adkins		First	Middle
4. DATE OF DEATH Mar 26 1958		Last	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 23 1875
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Denard Adkins		14. MOTHER'S MAIDEN NAME Sally Ann Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordis</u> <u>Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH UNK			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 5</u> , 1958, to <u>Mar 26</u> , 1958, that I last saw the deceased alive on <u>Mar 26</u> , 1958, and that death occurred at <u>1042 1/2 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1042 1/2 M</u> DATE SIGNED <u>Mar 26 1958</u>			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. <u>Mar 26 1958</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>		Eastern Shore State Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/58	22c. NAME OF CEMETERY OR CREMATORIUM PARSONS CEMETERY
22d. LOCATION (City, town, or county) SALISBURY, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co SALISBURY, MD		24a. REC'D BY REGISTRAR DATE MAR 28 '58	24b. REGISTRAR'S SIGNATURE <u>Refused</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATA

520

BUREAU Y.

MAY 22 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3261 CERTIFICATE OF DEATH

Reg. Dist. No. 03210

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 4 Years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		f. STREET ADDRESS Glenburn Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jane	Middle	Last Anderson	4. DATE OF DEATH	Month 3	Dy 5	Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/1889	9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY X		11. BIRTHPLACE (State or foreign country) Drexel Hill, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edgar T. Anderson		14. MOTHER'S MAIDEN NAME Jane Hopkins		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Convalescent Home Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Generalized rheumatoid arthritis (severe)		20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m. 19				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/10, 1955, to 3/5, 1958, that I last saw the deceased alive on 3/5, 1958, and that death occurred at <input type="checkbox"/> M, from the causes and on the date stated above. ACTUAL SIGNATURE W.H. Hanks M.D.		ADDRESS (Street, city or town, state) 1046 Locust St Cambridge, Maryland				DATE SIGNED 3/5/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Crest Cemetery		22d. LOCATION (City, town, or county) Trucksville, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE Albert J. LeCompte			

射频识别技术与应用 第1章 识别技术与RFID系统概述 17

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MAR 26 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3262

CERTIFICATE OF DEATH

Reg. Dist. No.

03220

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN Tb 2yr. 5mo. 4das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. STREET ADDRESS 426 Washington Street		d. STREET ADDRESS 426 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elisa	First	Middle	Last Arnie
4. DATE OF DEATH March 7 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-90
9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Switzerland	12. CITIZEN OF WHAT COUNTRY? Switzerland
13. FATHER'S NAME Kasper Stocker	14. MOTHER'S MAIDEN NAME Elisa Kung		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. -	17. INFORMANT RECORDS - Eastern Shore State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure			
DUE TO (b) Hypertensive Arteriosclerotic Cardiac Disease			
DUE TO (c) Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) -		(County) -	
		(State) -	
21. I certify that I attended the deceased from June 1, 1957 to March 7, 1958 , that I last saw the deceased alive on March 7, 1958 , and that death occurred at 7-20 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Eastern Shore State Hosp.			
DATE SIGNED Ettore De Filippis M.D.			
ACTUAL SIGNATURE Ettore De Filippis M.D.			
PHYSICIAN'S NAME (Type) ETTORE DE FILIPPIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/1958	22c. NAME OF CEMETERY OR CREMATORIAL Cash New Market	22d. LOCATION (City, town, or county) Cash New Market
(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas Cambridge Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 11 '58
			24b. REGISTRAR'S SIGNATURE Att-eae

WILSON'S ALMANAC FOR 1939-1940

CERTIFICATE OF OWNERSHIP

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3263

CERTIFICATE OF DEATH

Reg. Dist. No. 03221

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 13 months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonsville		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. FIRST MIDDLE LAST Glady May Baker		4. DATE OF DEATH March 4, 1958		Month March		Day 4		Year 1958	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 12, 1929		9. AGE (In years lost birthday) 28 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Bayard Baker		14. MOTHER'S MAIDEN NAME Anna M. Summers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT RECORDS: Eastern Shore State Hospital Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		DUE TO 430.1		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Chronic Myocarditis		DUE TO 430.1		Over 1 yr.			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Mental Deficiency, severe, with psychosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 25, 1957 to March 4, 1958 that I last saw the deceased alive on March 3, 1958 , and that death occurred at 1:45 A M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 3-4-58					
ACTUAL SIGNATURE Harry J. Crawford		M.D. Cambridge, Md.							
PHYSICIAN'S NAME (Type) Harry J. Crawford		Eastern Shore State Hospital, Cambridge, Md.							
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF March 6-58		22c. NAME OF CEMETERY OR CREMATORIUM Grasonville		22d. LOCATION (City, town, or county) Grasonville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE James H. Baker, Jr. of Baker Bros., Cambridge, Maryland		ADDRESS 1618 Main Street, Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE Mar 6 '58		24b. REGISTRAR'S SIGNATURE John H. Baker, Jr.			

REGELIV ED
MAR 6 1988
BUREAU Y. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3234

CERTIFICATE OF DEATH

Reg. Dist. 03222

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 25 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 249 Race St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas		First Howard	Middle Bennett	Last Mar.	DATE OF DEATH 21	Month Mar.	Day 19	Year 58
4. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/13/79		
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years lost birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Hills Point Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas J. Bennett				14. MOTHER'S MAIDEN NAME Della Wheatley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Thomas Bennett		Address 249 Race St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO c)		Cerebral Hemorrhage Cerebral arterio sclerosis				INTERVAL BETWEEN ONSET AND DEATH 9 days 39 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ 3/15, 1977, to _____ 3/24, 1977, that I last saw the deceased alive on _____ 3/24, 1977, and that death occurred at _____ 1:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.						ADDRESS (Street, city or town, state) 136 Race St. DATE SIGNED		
PHYSICIAN'S NAME (Type) Lawrence Maryanov M.D.								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/58		22c. NAME OF CEMETERY OR CREMATORIAL Speddens-Seward		22d. LOCATION (City, town, or county) James Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE APR 1 '58		24b. REGISTRAR'S SIGNATURE C. L. C.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3235

CERTIFICATE OF DEATH

03223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 20 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS Mill St. Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home Mill St. Cambridge Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vernon		First	Middle A.	Last Bradley	4. DATE OF DEATH Mar.	Month 18	Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/78	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Preston Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bradley				14. MOTHER'S MAIDEN NAME Emily Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Vernon Bradley		Address Mill St. Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 X Uremia						INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		(b) Arterio-sclerotic C-V-R disease				2 years	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Feb. 21, 1957, to Mar. 18, 1958, that I last saw the deceased alive on Mar. 18, 1958, and that death occurred at 3:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 6 Church St. Cambridge, Md. 3/31/58							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. John lace Jr.		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/58	22c. NAME OF CEMETERY OR CREMATORIAL Washington Cemetery		22d. LOCATION (City, town, or county) Hurlock		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE LeCompte Cambridge Md.	

EDWARD V. S.

13-1000

EDWARD V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3236

CERTIFICATE OF DEATH

Item 811-2213-20-54 et

03224

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge Md.

c. LENGTH OF STAY IN 1b

6 Yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

415 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Md.

b. COUNTY

Dorchester Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge Md.

d. STREET ADDRESS

415 Maryland Ave.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First Angie Middle Ronia

Last Bramble

4. DATE OF DEATH
Month Mar. Day 15, Year 1958

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 1861 1865

9. AGE (In years
lost birthday) yrs

92

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Bishops Head Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Washington Bramble

14. MOTHER'S MAIDEN NAME

Mary Horseman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs Reuben Bramble

Address

415 Maryland Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Squamous cell carcinoma of

face with extension into

eye, orbit and brain

INTERVAL BETWEEN
ONSET AND DEATH

10 years

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Nov. 1954 to Mar 15, 1958 that I last saw the deceased alive on Mar. 14, 1958, and that death occurred at 6 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/18/58

22c. NAME OF CEMETERY OR CREMATORI

St. Thomas Church

22d. LOCATION (City, town, or county)

(State)

Bishops Head

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

Cambridge Md.

24a. REC'D BY REGISTRAR

MAR 26 '58

24b. REGISTRAR'S SIGNATURE

Lewis M. Burdette

RECEIVED
BUREAU V. S.

MAR 26 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3237

CERTIFICATE OF DEATH

Reg. Dist. 03225

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md. Shoal Creek				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Cambridge Md. Shoal Creek.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) M. Clayton		First	Middle	Last	4. DATE OF DEATH Mar. 17, 1958	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/97	9. AGE (in years last birthday) 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Sewage Dept.		11. BIRTHPLACE (State or foreign country) Church Creek Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Goodman W. Bramble		14. MOTHER'S MAIDEN NAME Sarah Jane Asplen						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 098-05-4373		17. INFORMANT Mrs. Clayton Bramble Cambridge Md. Shoal Creek		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 57dx DUE TO Arthritis INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) Ch. Arthritis ONSET AND DEATH lying cause lost. (c) 5 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fractured. Asthma						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/15 , 19 58 to 3/17 , 19 58 , that I last saw the deceased alive on 3/17 , 19 58 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE M. H. Hanks M.D. 104 Locust St DATE SIGNED 3/17/58 PHYSICIAN'S NAME (Type) W.H. Hanks ADDRESS Cambridge Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS		24a. REC'D BY REGISTRAR Mar 26 '58		24b. REGISTRAR'S SIGNATURE LeCompte		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MURKAU V. 8

MAR 26 1963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03227

Reg. Dist. No.

3264

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		d. STREET ADDRESS Worl Neck					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Worl Neck				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Agdalene		First Agdalene	Middle Henry	Last Chase	4. DATE OF DEATH March 25, 1903	Month March	Day 25	Year 1903			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1903 9. AGE (In years last birthday) 55 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Maryland					
13. FATHER'S NAME John D. Henry			14. MOTHER'S MAIDEN NAME Susan E. Thompson			12. CITIZEN OF WHAT COUNTRY? USA					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William L. Chase, Vienna, Md. R.R.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									<small>INTERVAL BETWEEN ONSET AND DEATH 2 hrs.</small>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage											
33/X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19		Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Vienna		(County) Maryland	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mac Jr.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John Mac Jr. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											DATE SIGNED 3/21/53
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/53		22c. NAME OF CEMETERY OR CREMATORIUM Worl Neck Cemetery			22d. LOCATION (City, town, or county) Vienna				
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Brampton & Son, Federalsburg, Md.				ADDRESS J. J. Brampton & Son, Federalsburg, Md.		24a. REC'D BY REGISTRAR MAR 25 '53		24b. REGISTRAR'S SIGNATURE <i>John Mac Jr.</i>			
VS. ATSM(S) SM 9/55											

RECEIVED

MAR 26 1958

BUREAU V. S.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, he should file it with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3265

CERTIFICATE OF DEATH

03228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		1. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		b. COUNTY Dorchester	
c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Finchville		d. STREET ADDRESS Near Finchville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alberta		First Middle Virginia	4. DATE OF DEATH March 1 1958
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 22, 1912		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Evans		14. MOTHER'S MAIDEN NAME Sadie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-12-0157	
17. INFORMANT Fred Collins, Federalsburg, Maryland RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hypertensive cardiovascular disease Obesity, endogenous	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-1958, to 2-25-1958, that I last saw the deceased alive on 2-28-1958, and that death occurred at 8:15 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) John C. Rawlins, M.D. 202 5th St., Seaford, Del. DATE SIGNED 3-3-58	
ACTUAL SIGNATURE John C. Rawlins M.D.		PHYSICIAN'S NAME (Type) John C. Rawlins, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 5, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Cokesbury Cemetery		22d. LOCATION (City, town, or county) Near Federalsburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE MAR 6 '58	
		24b. REGISTRAR'S SIGNATURE A. L. esuch	

MEAU V. S.

MAR 6 1923

MEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03229

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

		Reg. Dist. No. _____									
3238											
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission on) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN lb <u>Life</u>		d. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>5 Charles St.</u>									
3. NAME OF DECEASED (Type or print) <u>Sarah Catherine Elizabeth Conaway</u>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1845</u>	9. AGE (in years from b. (today)) <u>72</u> yrs			10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Elaine Woolford</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pinder</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>James Conaway</u> Address <u>3 Charles St., Cambridge</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO <u>783.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>30 mins.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)									
20c. TIME OF INJURY Month, Day, Year HOUR <u>o. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3 Charles St., Cambridge</u>		20f. (City or town) <u>Salem</u> (County) <u>W. Va.</u> (State) <u>W. Va.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>3/2/58</u>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) <u>Salem</u> (State) <u>W. Va.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert S+Clair</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Herb Clair</u>					

BUREAU V. S.

MAR 12 1933

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03230

CERTIFICATE OF DEATH

Reg. Dist. No.

3239

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md. 27 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Light St.		d. STREET ADDRESS 16 Light St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mamie		First Woolen	Middle Condon
4. DATE OF DEATH Mar. 11, 1958		Month Mar.	Day 11
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9/13/70		9. AGE (In years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Woolen		14. MOTHER'S MAIDEN NAME Mary E. Horney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT Miss. Beatrice Condon Cambridge Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 142.8		INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-5-46, 19, to 3-11-58, 19, that I last saw the deceased alive on 3-9-58, 19, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Albert E. Bunker, M. D. Physician's NAME (Type) Albert E. Bunker, M. D.		M.D. 200 Maryland Avenue Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/58	22c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery
22d. LOCATION (City, town, or county) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '58	24b. REGISTRAR'S SIGNATURE A. S. Seach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THEATRE V. S.

22 1929

THEATRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3240

CERTIFICATE OF DEATH

04535

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Dorchester MARYLAND		Antrimtown Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
CAMBRIDGE	60 yrs.	CAMBRIDGE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Ollie	First Middle Last Cornish		Month Day Year 3 1 1958			
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
M	Neato		July 16 1882	75		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State of foreign country)	12. CITIZEN OF WHAT COUNTRY? Dolchester Co. Md U. S. A.			
Labourer	NONE	Dolchester Co. Md				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
JAKE Cornish	SARAH Augustus Lawes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes W.W.I	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
	214-077314	DAISEY HOWARD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Intestinal Obstruction					
577.0	DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)	DUE TO					
	(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
Nutritional and Vitamin deficiency						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 2-27-1958 to 3-1-1958 that I last saw the deceased alive on 2-28-1958, and that death occurred at 1:20 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert E. Bunker</i> ADDRESS (Street, city or town, state) 314 Cambridge, Md PHYSICIAN'S NAME (Type) Albert E. Bunker M.D. Cambridge Maryland	DATE SIGNED 3/1/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Bethel	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or county) Cambridge	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John McHenry Cambridge</i>	24a. REC'D BY REGISTRAR DATE APR 10 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Bunker</i>				

UNIVERSITY

APR 10 1983

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3266

CERTIFICATE OF DEATH

03232

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - RURAL MD			
3. NAME OF DECEASED (Type or print) John		First Middle Last A. H. DOLBY	4. DATE OF DEATH March 25 1958		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19 1872		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME HIRAM DOLBY		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Eastern Shore State Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <u>Mar 13</u> , 1958, to <u>Mar 25</u> , 1958, that I last saw the deceased alive on <u>Mar 24</u> , 1958, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. <u>Mar 25</u> , 1958 PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 27, 1958	22c. NAME OF CEMETERY OR CREMATORIAL JUNIOR ORDER CEMETERY	22d. LOCATION (City, town, or county) LINCHESTER, MARYLAND (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Brampton Son</u>	ADDRESS Federalburg, Md.	24a. READ BY REGISTRAR DATE MAR 27 '58	24b. REGISTRAR'S SIGNATURE <u>Q. H. Deane</u>		

PRIMAVERA

REGGIEVILLE

MAR 27 1959

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M P/55

1. PLACE OF DEATH a. COUNTY Fincaster MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Marys					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Cambridge		c. LENGTH OF STAY IN lb 1yr. 9mo. 12days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS -					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Tykes	4. DATE OF DEATH March 20 1958	Month March	Day 20	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-70	9. AGE (In years and birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -None			10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Miller				14. MOTHER'S MAIDEN NAME Mary Etta Gibbons					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT S - Eastern Shore State Hospital	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 d. 1. DUE TO Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic Myocarditis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO (c) General Arteriosclerosis									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Eastern Shore State Hosp.	(County)	(State)		
21. I certify, that I attended the deceased from <u>Very</u> , 1957, to <u>Mar. 20</u> , 1958, that I last saw the deceased alive on <u>Mar. 20</u> , 1958, and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE ETTORE DE FILIPPI				ADDRESS (Street, city or town, state) Eastern Shore State Hosp. Cambridge, Md.					
DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 3/23/58	22c. NAME OF CEMETERY OR CREMATORIAL Very Last		22d. LOCATION (City, town, or county) Princess Anne Md	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James Neaman				ADDRESS Maurice Jones	24a. RECEIVED BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE John C. Clark			

BUREAU Y. S.

MAR 26 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03234

Reg. Dist. No.

3268

1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE Maryland		c. COUNTY Harford Co.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Cambridge		12 yrs.		Perryville		Perryville											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. DATE OF DEATH		Month		Doy Year									
Eastern Shore State Hospital				Evans		March		4 19 58									
3. NAME OF DECEASED (Type or print)		First Middle		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR, MONTHS		11. IF UNDER 24 HRS, DAYS	
William				Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/6/78 X		79 yrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Cement worker		Construction		Maryland		U.S.A.											
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
Jefferson Evans				Margaret Cancon													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address											
Unknown						Records Eastern Shore State Hospital											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion										Instant					
400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				(b) Arteriosclerosis								?					
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Psychosis with cerebral arteriosclerosis																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>John Evans Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/4/58							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/8/58		22c. NAME OF CEMETERY OR CREMATORIAL Asbury Cem.		22d. LOCATION (City, town, or county) Cecil, Md											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Elkton, Md		24a. REC'D BY REGISTRAR DATE MAR 11 '58		24b. REGISTRAR'S SIGNATURE Debbie											

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MR. 1230

REGIMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03235

3269

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek Md.		c. LENGTH OF STAY IN 1b 60 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek Md.		d. STREET ADDRESS Fishing Creek Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fishing Creek Md.				d. STREET ADDRESS Fishing Creek Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ivy		First Ivy	Middle B.	Last Flowers	4. DATE OF DEATH March	Month 17	Day 19	Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1890	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Barren Island Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Alfred T. Flowers		14. MOTHER'S MAIDEN NAME Carrie Smith								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I		17. INFORMANT Mrs. Lillie Flowers		Address Fishing Creek Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Generalized metastases 9 months								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Carcinoma of prostate 9 months								
DUE TO (c)		Carcinoma of ureter & of bladder 9 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Md.	(State) Md.	
21. I certify that I attended the deceased from 6/3/57 , 19, to 3/17 , 19, Id that I last saw the deceased alive on 3/16 , 19, Id , and that death occurred at 12:30 M, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md.								DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Cemetery Fishing Creek Cemetery		22d. LOCATION (City, town, or county) Cambridge Fishing Creek		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. RECEIVED BY REGISTRAR MAR 26 '58		24b. REGISTRAR'S SIGNATURE Web Queen				

BUREAU V. S.

MAR 26 1958

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03236

Reg. Dist. No.

3241

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Dor.</u>	
<u>Dorchester</u> MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Cambridge Hospital</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Spencer Jones Labor Camp.</u>	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>Baby</u>		f. DATE OF DEATH Month <u>5</u> Year <u>1958</u> (75) 19	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/58</u>
M	Negro		9. AGE (In years last birthday) yrs. <u>3</u> Month <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mozanna Friend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>000-00-0000</u>	
17. INFORMANT <u>John Luce Jr. L.D.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (cause unknown)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Cambridge</u> (County) <u>Maryland</u> (State) <u>M.D.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Luce Jr. L.D.</u>		DATE SIGNED <u>3/15/58</u>	
EXAMINER'S NAME (Type) <u>John Luce Jr. L.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 18, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Near Hurlock, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>John Luce Jr. L.D.</u> DATE <u>3/18/58</u>	
25. REGISTRAR'S SIGNATURE <u>John Luce Jr. L.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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MAR 18 1960

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03237

3270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN lb 11 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		d. STREET ADDRESS Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher's Nursing Home						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle WOODLAND	Last GOSLEE	4. DATE OF DEATH Sept. 25, 1868	Month 3	Day 7	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1868	9. AGE (in years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Orson Goslee		14. MOTHER'S MAIDEN NAME Jane Jenkins						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. George F. Goslee, Hebron, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
(b) DUE TO Generalized Arteriosclerosis						20 yrs		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sept. 15</u> , 1957, to <u>March 7</u> , 1958, that I last saw the deceased alive on <u>3-3-58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joe B. Plummer</u> PHYSICIAN'S NAME (Type) <u>Dr. Harold Plummer</u>						ADDRESS (Street, city or town, state) <u>Preston, Maryland</u> DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/58		22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Pk.		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co, Salisbury, Maryland		ADDRESS Norman F. Baker		24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE Albert J. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU Y.

MAR 12 1953

REATIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3271

CERTIFICATE OF DEATH

03238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Margaret		First Condon	Middle Greenwell	Last March 11, 1958	Month 19	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 10, 1884	9. AGE (in years less birthday) 73	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, R.D.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Condon		14. MOTHER'S MAIDEN NAME Priscilla						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT J. Clyde Greenwell, Cambridge, R.D.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. --- (b) Arteriosclerotic cardio vascular renal disease DUE TO (c) Arteriosclerosis generalized						INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. --- 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) (State)
21. I certify that I attended the deceased from 2-23-58 , 19 19 , to 3-11-58 , 19 19 , that I last saw the deceased alive on 3-10-58 , 19 19 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 15 Locust Street, Cambridge, Md.		DATE SIGNED 3-12-58
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>								
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Catholic Churchyard		22d. LOCATION (City, town, or county) Secretary, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Showers - Cambridge, Md.</i>		ADDRESS				24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE <i>W.L. edwards</i>

RECEIVED
MAY 17 1955
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03239

3272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
-b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		d. STREET ADDRESS R.D.# 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edith		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH Oct 29 1876		9. AGE (In years lost birthday) 81 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Somerset County Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Alexander Murrell			14. MOTHER'S MAIDEN NAME Mary Ellen Jones						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. W. Murrell McGrath -R.D.# 1 Eastern Shore State Hospital records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) general Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Unk
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Allen	(County)	(State)	
21. I certify that I attended the deceased from <u>Nov 8</u> , 1955, to <u>Mar 8</u> , 1958, that I last saw the deceased alive on <u>Mar 7</u> , 1958, and that death occurred at <u>Allen</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md.									
DATE SIGNED March 8, 1958									
ACTUAL SIGNATURE Thomas J. Dredge		PHYSICIAN'S NAME (Type) Thomas J. Dredge MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 11, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Allen Cemetery		22d. LOCATION (City, town, or county) Allen, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE Albert Beuch			

BUREAU Y.

1993

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3273

CERTIFICATE OF DEATH

03240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 2 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 303 Willis		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) August - Theodore Groll		First	Middle	Last	4. DATE OF DEATH March 2 1958	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13 1884		9. AGE (in years lost birthday) 93 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMER		10c. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME August Groll		14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eastern Shore State Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>General Arteriosclerosis</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO <u>LNA</u> lying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County)	(State)
21. I certify that I attended the deceased from <u>Jan 8</u> , 1958 to <u>Mar 2</u> , 1958, that I last saw the deceased alive on <u>Jan 7</u> , 1958, and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md.									
PHYSICIAN'S NAME (Type) Thomas J. Dredge									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/58		22c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '58		24b. REGISTRAR'S SIGNATURE C. LeCompte			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUJEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3242

CERTIFICATE OF DEATH

Reg. Dist. No.

03241

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 237 Race St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS 237 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Brice		First Edward	Middle Hill	Last Hill	4. DATE OF DEATH Mar.	Month 3	Day 1958	Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/10/37	9. AGE (In years lost birthday) 20 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wesley Hill		14. MOTHER'S MAIDEN NAME Margaret Bell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wesley Hill		Address 237 Race St. Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Multiple Hemorrhages		INTERVAL BETWEEN ONSET AND DEATH 5 days			
DUE TO Thrombocytopenia		(c)		Aplastic Anemia		1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Dorchester	(State) Md.
21. I certify that I attended the deceased from alive on		2/20/58, 19		to		3/4/58, 19		that I last saw the deceased died at 6 AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE Physician's NAME (Type) Lawrence Maryanov				ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md.		DATE SIGNED 3/4/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR MAR 7 '58		24b. REGISTRAR'S SIGNATURE A. LeCompte			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MONDAY, 7

8:27 1933

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3243

CERTIFICATE OF DEATH

Reg. Dist. No.

03242

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital			d. STREET ADDRESS Petersburg			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Noah	Middle Vlademir	Last Hill	4. DATE OF DEATH March 5 1958	Month March	Day 5	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 16, 1907	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Continental Can Co.		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Clarence Hill			14. MOTHER'S MAIDEN NAME Delia Jolley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 117-14-9091		17. INFORMANT Mrs. Delia Hill, Hurlock, Maryland, R.F.D.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO 40% Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO C PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO C INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 <input type="checkbox"/> p. m. 3/4 1958 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from 3/4 1958 to 3/5 1958 , that I last saw the deceased alive on 3/5 1958 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter E. Gunby Jr.</i> ADDRESS (Street, city or town, state) 105 CHURCH ST. DATE SIGNED WALTER E. GUNBY JR CAMBRIDGE MD.								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF March 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Petersburg Cemetery		22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D. BY REGISTRAR MART 3 1958		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

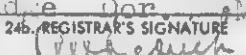
BUREAU V. S.

RECEIVED
MAR 22 1963

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 60 Yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md.		e. STREET ADDRESS 145 Appleby Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 145 Appleby Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Otto		First Middle H. Hoge		4. DATE OF DEATH March 12 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/82	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing		10b. KIND OF BUSINESS OR INDUSTRY Wire Cloth Co.		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William F. Hoge		14. MOTHER'S MAIDEN NAME Eliza Fischer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Earl Hoge		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) Arteriosclerotic C.V. disease							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				DATE SIGNED 3/13/58			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR MAR 18 '58		24b. REGISTRAR'S SIGNATURE 	
VS. A15ME(5) 5M 9/55							

DAU V. 2

MAR 19 1968

THE GENEVA FILE

03244

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

		Reg. Dist. No. _____					
1. PLACE OF DEATH a. COUNTY		3245 Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 4 days		b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Vienna	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital				d. STREET ADDRESS n.e. D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas		First Henry		e. MIDDLE Horsman		4. DATE OF DEATH Month March 13 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 26, 1865		9. AGE (in years from birthday) 93 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Darius Horsman				14. MOTHER'S MAIDEN NAME Margaret Hughes		Address Vienna, Md. RG.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Son Powell Horseman		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.1 Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. TIME OF INJURY Month, Day, Year Hour _____ a.m. 3/13/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home		20f. (City or town) Maryland (County) (State)	
23. MEDICAL CERTIFICATION							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/58		22c. NAME OF CEMETERY OR CREATORY Family Lot		22d. LOCATION (City, town, or county) Gryffiths Beach, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Willoughby Funeral Home East New Market				DATE MAR 17 '58		Allie Lewis	

BUREAU V, S

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03245.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		3246		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge		Md	
c. LENGTH OF STAY IN 1b		3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Cambridge Maryland		Vienna	
d. STREET ADDRESS				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
Robert		Winfred	Hurley	5	13
5. SEX Male		6. COLOR OF FACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1895	9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Jewelry		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert N. Hurley		14. MOTHER'S MAIDEN NAME August Hurley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Hurley, Elliott Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 18 days			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CEREBRAL HEMORRHAGE			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from		21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from
alive on		21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from
ACTUAL SIGNATURE		21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from
PHYSICIAN'S NAME (Type)		21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from	21. I certify that I attended the deceased from
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)
Burial 3/15/58		Vienna	Vienna	Vienna	Md
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Dutch J. Hollingsby East New Market			DATE MAR 21 1958	Alfred Hurley	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IRZAU V. 8

APR 11 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03246

3274

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 7yr 8mo 8days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. Michaels		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle Sidney	Last Jones	4. DATE OF DEATH Mar 11 1958	Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 26 1906	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas B. Jones		14. MOTHER'S MAIDEN NAME Lottie Harrison						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				B broncho-Pneumonia		INTERVAL BETWEEN ONSET AND DEATH YR.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from Mar 1, 1958, to Mar 11, 1958, that I last saw the deceased alive on Mar 10, 1958, and that death occurred at 7:35 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 3-11-58
ACTUAL SIGNATURE Thomas J. Dredge		PHYSICIAN'S NAME (Type) Thomas J. Dredge		E.S.S. Hospital, Cambridge, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1958		22c. NAME OF CEMETERY OR Crematory Aveant Cemetery		22d. LOCATION (City, town, or county) NEAVANT, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. Hambleton Harrison		ADDRESS St. Michaels, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE Webb		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MAR 17, 1928

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-5.10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3247 CERTIFICATE OF DEATH

03247

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Dorchester	MARYLAND	STATE Maryland	COUNTY Wicomico ✓
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (In this place) 8 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela Springs (If rural give location)	
Cambridge Hospital		STREET ADDRESS Bridge		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)		
Arthur Thomas Lloyd		Mar. 13 19 58		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4-29-1888	9. AGE last birthday 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monuments - owner		10b. KIND OF BUSINESS OR INDUSTRY Stone	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Lloyd		12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT & ADDRESS Virginia Robinson, Mardela Springs	
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA.</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>160X</u> (C) _____ IX OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARDIOVASCULAR DISEASE</u> <u>DIABETES MELLITUS</u> ?				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/6 19 58</u> , to <u>3/13 19 58</u> , that I last saw the deceased alive on <u>3/13 19 58</u> , and that death occurred at <u>1:12 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Walter E. Gunby Jr.</u> M.D. ADDRESS <u>105 Cambridge St</u> DATE SIGNED <u>17 MARCH 58</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				
DATE THEREOF 3-16-58		NAME OF CEMETERY OR CREMATORIAL Mardela		LOCATION (City, town, or county) Mardela Springs, Md. (State)
24. REC'D BY REGISTRAR MAR 17 '58 DATE		REGISTRAR'S SIGNATURE Albert Leach		
		25. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gray, Daytown		

BUREAU V.

JUN 17 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 3275 CERTIFICATE OF DEATH

03248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Secretary</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>	
3. NAME OF DECEASED (Type or print) <i>William B. Mantik</i>		d. STREET ADDRESS <i>—</i>	
4. SEX <i>Male</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>6/17/1880</i>
8. DATE OF DEATH <i>3/6/57</i>	9. AGE (In years on day of death) <i>77 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. DEATH OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Mantik</i>		14. MOTHER'S MIDDLE NAME <i>Katherine Filipiak</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. OR INFORMANT <i>Mrs Mary Mantik, Secretary Md</i>	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1960</i> DUE TO <i>Acute Cardiac Dicompensation</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Dehydration + malnutrition</i> 6 months (c) <i>Removed Sarcoma of right jaw</i> 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-2</i> , 19 <i>56</i> , to <i>3-6</i> , 19 <i>57</i> that I last saw the deceased alive on <i>3-6</i> , 19 <i>58</i> , and that death occurred at <i>9 1/2 M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jacy B. Plummer</i> M.D. ADDRESS (Street, city or town, state) <i>Preston Md</i> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 3/10/1958</i>		22b. DATE THEREOF <i>3/10/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Secretary Dorchester</i>		22d. LOCATION (City, town or county) (State) <i>Secretary Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lucy Hollingsby, C. A. Macta</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 31 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>—</i>			

BUREAU N.Y.

17 31 1929

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3248

CERTIFICATE OF DEATH

03249

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS AIS (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) David		First A	Middle Mc Cready
4. DATE OF DEATH March 22 1958		Last 7	Month March
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 6, 1887
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mc Cready		14. MOTHER'S MAIDEN NAME Dorothy Ennells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 6*	
17. INFORMANT Edward Mc Cready, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 5 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 17, 1958 to Mar 22, 1958 that I last saw the deceased alive on Mar 21, 1958 , and that death occurred at 1 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 RACE ST DATE SIGNED 3/25/58			
ACTUAL SIGNATURE Alfred R. Maryanov		M.D.	
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		CAMBRIDGE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert W. Mellany		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR APR 2 '58		24b. REGISTRAR'S SIGNATURE John C. Smith	

GEREAU N.Y.

1958

GEREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3276

CERTIFICATE OF DEATH

Reg. Dist. No.

03250

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambidge		c. LENGTH OF STAY IN 1b 4 yrs		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Trappe		d. STREET ADDRESS R.F.D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Matthias McMahan	4. DATE OF DEATH Month March	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1878	9. AGE (In years (on birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 26	12. Year 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Talbot County, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Matthias Franklin McMahan		14. MOTHER'S MAIDEN NAME Catherine Ross							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO none	17. INFORMANT unknown	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage 3 days. Cerebral Arteriosclerosis 2 yrs.						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 3/26, 1958	(County) 3/26, 1958	(State) 3/26, 1958				
21. I certify that I attended the deceased from 3/24, 1958 to 3/26, 1958 that I last saw the deceased alive on 3/26, 1958 , and that death occurred at 10 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 Race St. DATE SIGNED 3/27/58									
ACTUAL SIGNATURE Lawrence Maryanov		22. BURIAL, CREMATION, REMOVAL (Specify) Burial 3/29/58							
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Maryland		(State)			
24. ADDRESS Easton, Md.		24e. REC'D BY REGISTRAR DATE APR 2 '58		24f. REGISTRAR'S SIGNATURE Albanach					

SCHEIDAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3277

CERTIFICATE OF DEATH

Reg. Dist. No.

03251

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 7 yrs. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 117 Race Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Rollo	Middle -	Last Meekins	4. DATE OF DEATH March 23	Month March	Day 23	Year 1958		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Meekins			14. MOTHER'S MAIDEN NAME Lavenie Williams						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS: Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.0 DUE TO Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Chronic Arteriosclerotic Heart Disease							
DUE TO General Arteriosclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 19		Month May	Day 1957	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mar. 23, 1958	(County) Cambridge	(State) Md.	
21. I certify that I attended the deceased from May , 1957, to Mar. 23 , 1958, that I last saw the deceased alive on Mar. 23 , 1958, and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md.									DATE SIGNED 3-23-58
ACTUAL SIGNATURE Ettore De Filippis		M.D. Eastern Shore State Hosp. 3-23-58							
PHYSICIAN'S NAME (Type) Ettore De Filippis		Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/58		22c. NAME OF CEMETERY OR CREMATORIAL Ole Trinity Church, Church Creek, Md.		22d. LOCATION (City, town, or county) (State) Cambridge, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Bennet R. Thompson		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAR 28 '58		24b. REGISTRAR'S SIGNATURE Cambridge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNSWICK V. 2

1953

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03252

3249 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
3. NAME OF DECEASED (Type or print) First Middle Last Wilbur Hiram Meekins		4. DATE OF DEATH Month Day Year March 7, 1958 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1897		
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Acme Food Market		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Richard F. Meekins		14. MOTHER'S MAIDEN NAME Cornelia Andrews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Rosalie B. Meekins, 115 Gay St., Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause <u>her line</u> or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hr 22			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Herbal Sedation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. n. 19 p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 LOCUST ST	20f. (City or town) Cambridge	(County)	(State)
21. I certify that I attended the deceased from <u>11/31</u> , 19 <u>58</u> to <u>3/7</u> , 19 <u>58</u> that I last saw the deceased alive on <u>3/7</u> , 19 <u>58</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 LOCUST ST</u> DATE SIGNED <u>CAMBRIDGE MD</u> <u>3/8/58</u>					
ACTUAL SIGNATURE <u>K.H. Hawks</u>		PHYSICIAN'S NAME (Type) <u>K.H. Hawks</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery	22d. LOCATION (City, town, or county) East New Market, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>Mar 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. E. -</u>

BUREAU V. L.
48 11 1958
LAWRENCE

03253

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

3278

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge, Md.		c. LENGTH OF STAY IN lb 1yr 7mo 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hynson		4. DATE OF DEATH Month March Day 27 Year 19 58	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May, 31, 1880	
9. AGE (In years from birthdate) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Melvin		14. MOTHER'S MAIDEN NAME Esther Draper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Calcific aortic stenosis			
434.4 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac hypertrophy			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 753.7 Contusion of occipital region of head.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell, striking head on sharp edge of iron bed.	
20c. TIME OF INJURY Month, Day, Year Hour 5:30 XXX 3/27/ 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural		20f. (City or town) (County) Dorchester, Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Alfred R. Maryanov		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSIST DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/58	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive		22d. LOCATION (City, town, or county) Near Goldsboro, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Baileys		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR MAR 31 1958		24b. REGISTRAR'S SIGNATURE A. B. Schuch	

PEGGY V. S.

MAR 4 1953

PEGGY V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3279

CERTIFICATE OF DEATH

Reg. Dist. No.

03254

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Toddville Md.		d. STREET ADDRESS Toddville Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Victoria	First Robinson	Middle Meredith	4. DATE OF DEATH March 5, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Toddville Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Meredith		14. MOTHER'S MAIDEN NAME Emily Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fred Robinson		Address Toddville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE M. J. T. Reale PHYSICIAN'S NAME (Type) W. H. Hanks, M.D.		DATE SIGNED 3/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/58	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem Park	22d. LOCATION (City, town, or county) Cambridge (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR MAY 10 1958	
ADDRESS Cambridge Md.		24b. REGISTRAR'S SIGNATURE John A. Smith	

BRUNAU V. S.
MAR 2 1968
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

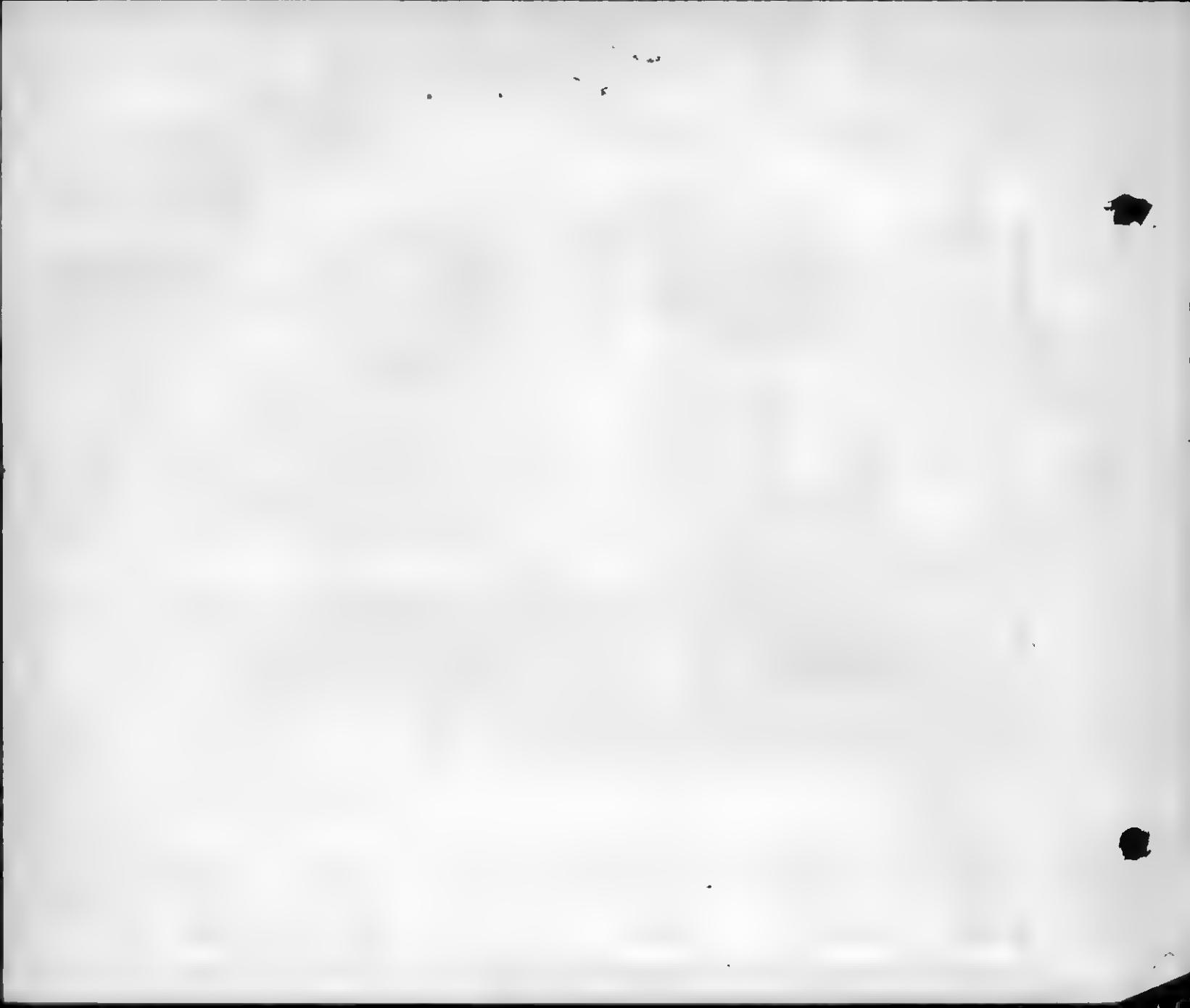
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CERTIFICATE OF DEATH

06788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Dorchester MARYLAND		MARYLAND Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
CAMBRIDGE		200-259	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
CAMBRIDGE MD. HOSPITAL Phillips St. (E.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Book	Middle Miller	4. DATE OF DEATH Month 3 - 26 Day Year 1958
5. SEX M.	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1919 ADD TO AGE 44 <input type="checkbox"/> AGE (In years at last birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY SAWMILL LABORER WOME	11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 248-01-4751	17. INFORMANT John Bell (Friend) Cambridge Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio</u>		INTERVAL BETWEEN ONSET AND DEATH ? <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio - atherosclerotic</u> <input type="checkbox"/> (c) <u>Arterio - atherosclerotic gen.</u> <input type="checkbox"/>		? <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Medication</u> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 24</u> , 1958, to <u>Mar 26</u> , 1958, that I last saw the deceased alive on <u>Mar 24</u> , 1958, and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. U. Thompson</u> M.D. ADDRESS (Street, city or town, state) <u>Cambridge Md.</u> DATE SIGNED <u>Mar 28, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Bellevue City</u>
22d. LOCATION (City, town, or county) <u>Cambridge</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		ADDRESS <u>Cambridge Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>
			24b. REGISTRAR'S SIGNATURE <u>Albert L. Eschuck</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3250

CERTIFICATE OF DEATH

Reg. Dist. No. 03255

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester Maryland		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Dor.	
Cambridge Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Secretary	
Cambridge Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Emma Rose Moxey		3 / 21 / 1958	
5. SEX		6. COLOR OF FACE	
Female		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		Divorced <input type="checkbox"/>	
4/7/1893		9. AGE (In years (on birthday) yrs.)	
10a. usual OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housework		Own home	
11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Havelick		Katherine Rossick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
—		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		Coronary artery thrombosis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)		26 weeks	
DUE TO		Arteriosclerosis	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/19/58 to 4/21/58, that I last saw the deceased alive on 4/21/58, and that death occurred at M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)		W.H. Flanagan 104 Locust St. 3/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial 3/24/58		22c. NAME OF CEMETERY OR Crematory	
22d. LOCATION (City, town or county)		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
E. J. Market, M.D.		DATE MAR 31 1958	
24b. REGISTRAR'S SIGNATURE		Q. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU M.E.

APR 27 1958

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3251 CERTIFICATE OF DEATH

Reg. Dist. No. **03256**

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Maces Lane		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 408 Maces Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel		First	Middle	Lost	4. DATE OF DEATH March 22 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 20, 1904	9. AGE (In years lost birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Opher		14. MOTHER'S MAIDEN NAME Emaline Mister							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-7781		17. INFORMANT Robert Opher, Madison, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO { DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 7 P.M.	(County) 227 Pine St-Cambridge, Md.	(State) 3-26-58
21. I certify that I attended the deceased from alive on March 22, 1958 , and that death occurred at 7 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>						DATE SIGNED			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/1958		22c. NAME OF CEMETERY OR CREMATORIUM Madison Cemetery		22d. LOCATION (City, town, or county) Madison, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Bellanca</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 2 '58		24b. REGISTRAR'S SIGNATURE <i>John J. Fassett</i>			

BUPEAY V. S

APR 2 1968

WELLS FARGO BANK
NATIONAL ASSOCIATION
SAN FRANCISCO, CALIFORNIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3252

CERTIFICATE OF DEATH

Reg. Dist. No.

03257

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 108 Race St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS 108 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Ruark	Last Pearson	4. DATE OF DEATH Mar. 29, 1958	Month Mar.	Day 29	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9/30/1900	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Lakesville Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Forney Ruark				14. MOTHER'S MAIDEN NAME Alverta White					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Virginia P. Miller		Address Arlington Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>Misc</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Nephrosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 6 mos									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County) Cambridge	(State) Md.			
21. I certify that I attended the deceased from Jan 8, 1958 , to March 29, 1958 that I last saw the deceased alive on 3-29-58 , and that death occurred at 7 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. Berman</i> M.D. ADDRESS (Street, city or town, state) Cambridge Md. DATE SIGNED 3-29-58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/58	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR APR 2 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours of death.

BUREAU VLS

08 2 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3253

CERTIFICATE OF DEATH

03258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek Md.		d. STREET ADDRESS Fishing Creek Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jermiah		First	Middle M.	Last Phillips	4. DATE OF DEATH Mar.	Month 31	Day 19	Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/80	9. AGE (in years last birthday) 77	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender		10b. KIND OF BUSINESS OR INDUSTRY Bridge Tender		11. BIRTHPLACE (State or foreign country) Golden Hill Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Phillips				14. MOTHER'S MAIDEN NAME Mary Burton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jermiah Phillips		Address Fishing Creek Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebrovascular Disease		Stomach		INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Anne Arundel	(State) Md.
21. I certify that I attended the deceased from 10/16/57 to 3/31/58, that I last saw the deceased alive on 3/31/58, and that death occurred at 1:37 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Physician's Name (Type) W.H. Hawkins									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/58		22c. NAME OF CEMETERY OR CREMATORIAL Hoosier Church Cemetery		22d. LOCATION (City, town, or county) Fishing Creek		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE APR 3 1958		24b. REGISTRAR'S SIGNATURE Q. B. Compte			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUDWEISER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03259

FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN lb 13 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital, Inc.		e. STREET ADDRESS 508 Pine Street	
3. NAME OF DECEASED (Type or print) Otis S. Pinder		4. DATE OF DEATH March 1 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Pinder		14. MOTHER'S MAIDEN NAME Lavinia (last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 217-10-8013	17. INFORMANT Address Record-Cambridge Maryland Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis due to DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute enteritis (a), stating the underlying cause lost. DUE TO (c) terminal broncho-pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardio vascular disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. —		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Hour — o. m. — p. m.	Month, Day, Year — — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —	(County) —	(State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1 March 58
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.	22b. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22c. DATE THEREOF 3/5/1958
22d. NAME OF CEMETERY OR CREMATORIAL Waugh Cemetery	22e. LOCATION (City, town, or county) Cambridge, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Schlesinger</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE MAR 6 1958	24b. REGISTRAR'S SIGNATURE <i>Olderich</i>

Y. S. *Y. S.*

MAR 6 1958

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3280

CERTIFICATE OF DEATH

Reg. Dist. No. 03260

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>		e. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) <u>RICHARD FRANKLIN PRICE</u>		First <u>—</u> Middle <u>—</u> Last <u>—</u>	4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1866</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Thomas Price</u>		14. MOTHER'S MAIDEN NAME <u>Helena Cochrane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Caroline Co. Welfare Board, Denton, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Cardio-Vascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>Feb. 15, 1958</u> , to <u>Mar. 15, 1958</u> , that I last saw the deceased alive on <u>March 15, 1958</u> , and that death occurred at <u>7:25 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ettore DeFilippis</u>	M.D.		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp.</u>		
DATE SIGNED <u>—</u>					
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>		Cemetery <u>BAMBURY CEMETERY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/17/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>BAMBURY CEMETERY</u>	22d. LOCATION (City, town, or county) <u>TRAPPE, B.D., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Hampton Carroll</u>		ADDRESS <u>—</u>	24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>	
VS A15 (4) 15M 9/55		DATE <u>MAR 19 '58</u>		—	

BUZEAU Y. S.

MAR 12 1974

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3281

CERTIFICATE OF DEATH

03261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Mos/		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescing Home		d. STREET ADDRESS 408 Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Mamie	Middle Elliott	Last Shorter	4. DATE OF DEATH Mar.	Month 29,	Day 1958	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/27/68	9. AGE (In years lost birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bishops Head Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Elliott				14. MOTHER'S MAIDEN NAME Caroline Wingate				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Audrey Blazek		Address Cambridge Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage Cerebral Arterio sclerosis INTERVAL BETWEEN ONSET AND DEATH 24 hours 20 yrs								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 3/28, 1958	(County) Cambridge	(State) Md.
21. I certify that I attended the deceased from <u>3/28</u> , 1958, to <u>3/28</u> , 1958, that I last saw the deceased alive on <u>3/28</u> , 1958, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 Race St DATE SIGNED 3/29/58								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	Lawrence Maryanov M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/58	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park			22d. LOCATION (City, town, or county) Cambridge			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR APR 2 '58	24b. REGISTRAR'S SIGNATURE G. L. Compte		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03262

3255 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Cambridge RFD # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First M.	Middle Edward	Last Slacum	4. DATE OF DEATH March 2, 1958	Month March	Day 2	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/76	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Steels Neck Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Slacum		14. MOTHER'S MAIDEN NAME Sally Elizabeth Sellers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Gertrude Slacum		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTER-SCLE-ROSES DUE TO (c)		19. INFORMANT Address		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) VIRAL INFECTION Acute 3 weeks		20c. TIME OF INJURY Hour p. m. 19		20d. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust St. Cambridge Ma		20f. (City or town) 312		(County) 312		(State) 312	
21. I certify that I attended the deceased from 7/19 , 19 58 , to 3/2 , 19 58 , that I last saw the deceased alive on 3/2 , 19 58 , and that death occurred at 312 M, from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hawks		ADDRESS (Street, city or town, state) 104 Locust St. Cambridge Ma		DATE SIGNED 3/3/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/58		22c. NAME OF CEMETERY OR CREMATORIAL Family Steels Neck		22d. LOCATION (City, town, or county) Dorchester Co.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REGISTRY BY REGISTRAR MAIN 9/38		24b. REGISTRAR'S SIGNATURE LeCompte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03263

3282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		b. COUNTY Dorchester	
c. LENGTH OF STAY IN b 31 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Steele's Neck Road		d. STREET ADDRESS Steele's Neck Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Donnie	First	Middle	4. DATE OF DEATH Smith March 4 1958
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		9. AGE (In years lost birthday) 56 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Franklin, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joshua Hampton		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-1678 17. INFORMANT George Mason, Vienna, Maryland, R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO High Blood Pressure		immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wear Scar	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 10/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 10, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery		22d. LOCATION (City, town, or county) (State) Rhodesdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Mar 10 '58	
		24b. REGISTRAR'S SIGNATURE G. L. Edwards	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNEAU V. S.

MAR 3 1968

LIBRARY
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03264

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE		Maryland		b. COUNTY		Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge, Md.		d. STREET ADDRESS 211 Cedar St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		211 Cedar St.											
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year					
George W.A.		Stanley			March 6								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. CITIZEN OF WHAT COUNTRY? USA	
Male		White	WIDOWED <input checked="" type="checkbox"/>	Oct. 4, 1890		67 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA							
Laborer		Farming		Maryland									
13. FATHER'S NAME		John Stanley		14. MOTHER'S MAIDEN NAME		Martina Young							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		220-09-1603		Derue Pinder		211 Cedar St., Cambridge, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion													
4/4/53 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/7/53			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/53		22c. NAME OF CEMETERY OR CREMATORIAL Salem Cemetery		22d. LOCATION (City, town, or county) Salem, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE <i>Albert E. Deutch</i>							

BUREAU V. 8

MAR 1933

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03265

Reg. Dist. No.

3283

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 13 mo. 21 days.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton			

16

3. NAME OF DECEASED (Type or print)		First Carrie	Middle Rebecca	Last Story	4. DATE OF DEATH March	Month March	Day 2	Year 1958
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-70	9. AGE (in years last birthday) 87 yrs.	10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Thomas Ware	14. MOTHER'S MAIDEN NAME Lucinda Anderson
----------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?	16. SOCIAL SECURITY NO. -	17. INFORMANT RECORDED - Eastern Shore State Hospital	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X		1 week
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture neck right femur 736.7		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Knocked down by another patient.		20c. TIME OF INJURY Month, Day, Year Hour 8.20 AM 11-9- 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Cambridge	(County) Dor.	(State) Md.
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>								
---	--	--	--	--	--	--	--	--

ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3/3/58
EXAMINER'S NAME (Type) John Mace Jr.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. CERIAL CREMATION, REMOVAL (Specify) May 5, 58	22b. DATE THEREOF May 5, 58	22c. NAME OF CEMETERY OR CREMATORIUM Crumpton	22d. LOCATION (City, town, or county) (State) Crumpton Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Edgar R Lane Church Hill	ADDRESS Edgar R Lane Church Hill	24a. REC'D BY REGISTRAR DATE Mar 7 1958	24b. REGISTRAR'S SIGNATURE John Mace Jr.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Fill in Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU U. S.

LIB 7 1920

15000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03266

Reg. Dist. No.

3284

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY 05		
b. CITY OR TOWN (If not in corporate limits, write RURAL and give nearest town) Taylors Island			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 401 Walton Ave.		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HARRY CLARK STULL			4. DATE OF DEATH March 11, 1958	Month	Day
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH About 1912	9. AGE (In years last birthday) 46 yrs.	IF UNDER 18 YRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ken Argy / Penn.	
13. FATHER'S NAME Roy A Stull			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Maxwell 56 Burbank St. Havre de Grace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9x19			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Found Drowned			
20c. TIME OF INJURY Month, Day, Year Hour a. m. unknown 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) unknown founds Taylors Island (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <i>Paul F. Guerin</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.			DATE SIGNED 3/12/58		
22a. BURIAL Cremation REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-13-58		22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	
22d. LOCATION (City, town, or county) Bethel Haven Pa.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Guerin</i>			24a. REC'D BY REGISTRAR Q18		
ADDRESS 122 Cook Ave. 1217 St Paul			24b. REGISTRAR'S SIGNATURE		
DATE MAR 14 '58					
VS. A15ME 5M 2/57					

BURLEY M.

10/14/1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3286

CERTIFICATE OF DEATH

03268

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>6-18-1956</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank</i>		First <i>F</i>	Middle <i>-</i>
4. DATE OF DEATH <i>June 27 1956</i>		Last <i>TARR</i>	Month <i>June</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-22-1889</i>		9. AGE (in years last birthday) yrs. <i>77</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	10c. BIRTHPLACE (State or foreign country) <i>Mass.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. MOTHER'S MAIDEN NAME <i>Mrs. Franklin Smith Penick</i>	
13. FATHER'S NAME <i>William TARR</i>		14. MOTHER'S MAIDEN NAME <i>Address</i> <i>515 Franklin Street, Baltimore, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>William TARR</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myopathy</i>	
DUE TO <i>Medical conditions</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis</i>		DUE TO <i>Medical conditions</i>	
DUE TO <i>Chronic Myopathy</i>		DUE TO <i>Medical conditions</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-12-56</i> to <i>3-30-57</i> , 1956, that I last saw the deceased alive on <i>5-8-56</i> , 1956, and that death occurred at <i>4:00 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin Ward</i> PHYSICIAN'S NAME (Type) <i>Edwin J. WARD</i>		ADDRESS (Street, city or town, state) <i>DATE SIGNED</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 1 1958</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>Holy Cross</i>		22d. LOCATION (City, town or county) (State) <i>Towson</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Penick, Jr.</i>		24a. REC'D BY REGISTRAR DATE APR 1 '58	
ADDRESS <i>2117</i>		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>	

BUREAU V. L

APR 1 1958

100-200-300

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03267

Reg. Dist. No.

PLACE OF DEATH
o. COUNTY

Dorchester

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
o. STATE Maryland

b. COUNTY Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cambridge

c. LENGTH OF STAY IN 1b
8 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Trappe

20 x - 2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eastern Shore State Hospital

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

EMILY

First

M.

Middle

TAYLOR

Last

4. DATE
OF
DEATH

Month
March

Day
25
Year
19 58

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

11/8/98

9. AGE (In years
from birthday)

59

10. IF UNDER 1 YEAR

Months
Years

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Secretary

10b. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oscar A. Mullikin

14. MOTHER'S MAIDEN NAME

Sarah E. Caryer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

If yes, give war or date of service

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Records E.S.S.H.

Address

Cambridge, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Terminal pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

1 day

331X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Cerebral hemorrhage

1 day.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Fracture neck right femur.

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell from chair.

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 8 PM
p. m. 1-24-58

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Hospital

20f. (City or town)
Cambridge

(County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John Mace Jr.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

3/25/58

22a. BURIAL, CREMATION, OR
REMOVAL (Specify)

22b. DATE THEREOF
3/28/58

22c. NAME OF CEMETERY OR CREMATORIUM
Upper Cambridge

22d. LOCATION (City, town, or county)
Easton (Md.)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Maurice E. Newman & Son

24a. REC'D BY REGISTRAR
DATE MAR 31 '58

24b. REGISTRAR'S SIGNATURE
A. E. Lewis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MH3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

BRUNAU V. S.

MR. 91 1953

BRUNAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03269

3287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>St. Michaels</i>						
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Roxy Hockett Thompson</i>	First	Middle	Last					
4. DATE OF DEATH <i>3/12/58</i>	Month	Day	Year					
5. SEX <i>Female</i>	6. COLOR OF HAIR <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/25/1884</i>					
9. AGE (In years at death) <i>74</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dogsewak</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Own Shop</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>					
13. FATHER'S NAME <i>James J. Hockett</i>	14. MOTHER'S MAIDEN NAME <i>Emma Collins</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>						
16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Roxy Thompson, St. Michaels, Md.</i>	Address <i></i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterosclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month <i>3</i>	Day <i>12</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Federal Building</i>	20f. (City or town) <i>Federal Building</i>	(County) <i>Md.</i>	(State) <i></i>
21. I certify that I attended the deceased from alive on <i>7-15-57</i> , and that death occurred at <i>8:53 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Federal Building, Md.</i>		DATE SIGNED <i>3-12-58</i>		
ACTUAL SIGNATURE <i>W. E. Lennon</i>	PHYSICIAN'S NAME (Type) <i>W. E. LENNON M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/14/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington</i>	22d. CLAYTON (City, town, or county) <i>St. Michaels</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Butts - Phillips E. N. Martin</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>MAR 19 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 10 1963

REGISTRY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director. File Pages 1 and 2 with the State Board of Health. If any delay is necessary, please give Pages 1, 2, and 3 to the funeral director. File Pages 1 and 2 with the State Board of Health. 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained by your files.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

103270

Reg. Dist. No.

3288

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge R.F.D. 2		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge R.F.D. 2	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First Middle Townsend	4. DATE OF DEATH March 1 Day 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Townsend		14. MOTHER'S MAIDEN NAME Zellina Banning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214 07 8500 17. INFORMANT Mrs. Helen Townsend, Cambridge, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Instant	
(b) Arteriosclerotic C-V Disease DUE TO (c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 3/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/58	
22c. NAME OF CEMETERY OR CREMATORIUM East New Market		22d. LOCATION (City, town or county) East New Market, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Full S. Hollingsby, C. N. Market</i>		24e. ADDRESS ADDRESS	
24f. REC'D. BY REGISTRAR DATE MAR 21 '58		24g. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

REAU V. S.

MAR 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03271

3257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS 302 Academy St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Thurman		First	Middle	Last	4. DATE OF DEATH Travers	Month Mar.	Day 13	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/30/29	9. AGE (In years last birthday) 29 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood Packing		11. BIRTHPLACE (State or foreign country) Fishing Creek Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Minnie G. Travers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Aaron		Address Cambridge Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Armenia</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Chv. M. plritis</u> ? DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>2/9</u> , 1958, to <u>2/13</u> , 1958, that I last saw the deceased alive on <u>2/13</u> , 1958, and that death occurred at <u>44</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>104 Locust St</u> DATE SIGNED <u>W.H. Hanks</u> <u>3/15/58</u>								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W.H. Hanks		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						
22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR MAR 18 '58				
				24b. REGISTRAR'S SIGNATURE Date				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TAU V. S.

MAR 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3289 CERTIFICATE OF DEATH

03272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edward	Middle -	Last White
4. DATE OF DEATH March	Month 20	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Mary White		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. - 17. INFORMANT Mrs. Russell Tingle-Zion Rd, Salisbury, Md. RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO <i>42 L.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>General Arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>Mar. 20</i> , 1958, that I last saw the deceased alive on <i>Mar. 20</i> , 1958, and that death occurred at <i>1145 M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ettore De Filippis</i> ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp</i> DATE SIGNED <i>3-21-58</i>			
22a. BURIAL, CREMATION, BURIAL (Specify) BURYAL		22b. DATE THEREOF March 23.58	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Pittsville Cemetery</i>		22d. LOCATION (City, town, or county) Pittsville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>	

ELLEN V. S

850



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3290

CERTIFICATE OF DEATH

03273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>		c. LENGTH OF STAY IN 1b <i>70 yrs</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Dorchester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>		d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Mae</i>	Last <i>Wilson</i>	4. DATE OF DEATH <i>3/17/1958</i>				
5. SEX <i>Female</i>	6. COLOR OF FACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/5/1865</i>	9. AGE (In years and days) <i>93</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min. <i></i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. PLACE (State or foreign country) <i>Maryland</i>	12. COUNTRY OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Michael Linkney</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Corkran</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Mrs Dorothy Deems, Secretary</i>	Address <i></i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		<i>2 months</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic heart disease		<i>8 yrs</i>
(c) Generalized Arteriosclerosis		<i>20 yrs</i>

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Preston</i>	(County) <i>Md.</i>	(State) <i></i>

21. I certify that I attended the deceased from <i>4-7, 1944</i> to <i>3-7, 1958</i> , that I last saw the deceased alive on <i>3-5, 1958</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>H. B. Plummer</i>	ADDRESS (Street, city or town, state) <i>Preston, Md.</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/9/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>	22d. LOCATION (City, town, or county) <i>East New Market, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. B. Plummer</i>	ADDRESS <i>110 E. New Market</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 31 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. Deems</i>

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU X. S

MAR 31 1933

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3258

CERTIFICATE OF DEATH

103274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS 213 West End Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First William	Middle Harvey	Last Wroten	4. DATE OF DEATH March 13, 1958	Month March	Day 13	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1898	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk, Canning	10b. KIND OF BUSINESS OR INDUSTRY Factory employee	11. BIRTHPLACE (State or foreign country) Church Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME John S. Wroten	14. MOTHER'S MAIDEN NAME Mary last name unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-07-9776	17. INFORMANT Mrs. Nicey C. Wroten, 213 West End Ave., Cambridge, Md.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG							INTERVAL BETWEEN ONSET AND DEATH ?	
163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last: (b) (c)							DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 12;15 A	(County)	(State)	
21. I certify that I attended the deceased from 6-14-50 , 19, to 3-13-58 , 19, that I last saw the deceased alive on 3-12-58 , 19, and that death occurred at 12;15 A , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED Albert E. Bunker M.D.								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D. Cambridge, Maryland								
22a. BURIAL, CREMATION, REMOVAL (specify) Burial	22b. DATE THEREOF March 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity	22d. LOCATION (City, town, or county) Church Creek, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR Mar 18 '58	24b. REGISTRAR'S SIGNATURE Albert E. Bunker					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED V. 2

MAR 18 1953

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